

FOR ACTIVE EMPLOYEES



STATE HEALTH BENEFIT PLAN

Active Decision Guide 2010

OPEN ENROLLMENT

October 9–November 10, 2009



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Phone Numbers/Contact Information

State Health Benefit Plan (SHBP): www.dch.georgia.gov/shbp_plans

Vendor	Member Services	Web Site
UnitedHealthcare		
HRA	800-396-6515	www.welcometouhc.com/shbp
OAP, HDHP, HMO	877-246-4189 TDD 800-255-0056	www.welcometouhc.com/shbp
CIGNA		
HRA, OAP, HMO, HDHP	800-633-8519 TDD 800-576-1314	www.mycigna.com/shbp
Pharmacy	Call vendor listed above	
SHBP Eligibility	404-656-6322 800-610-1863	www.dch.georgia.gov/shbp_plans

Disclaimer: The material in this booklet is for informational purposes and is not a contract. It is intended only to highlight principal benefits of the medical plans. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan documents, the Plan documents govern. It is the responsibility of each member, active or retired, to read all Plan materials provided in order to fully understand the provisions of the option chosen. Availability of SHBP options may change based on changes in federal or state law.

Page 3 of this guide contains Plan changes effective January 1, 2010. Prior to the start of the 2010 Plan Year, or shortly thereafter, the Plan will post a new Summary Plan Description (SPD) for each Plan option to the DCH Web site, www.dch.georgia.gov/shbp_plans. This SPD is your official notification of Plan changes effective January 1, 2010. You may print or request a paper copy by calling the Customer Service number on the back of your ID card. Please keep your SPD for future reference. If you are disabled and need this information in an alternative format, call the TDD Relay Service at (800) 255-0056 (text telephone) or (800) 255-0135 (voice) or write the SHBP at P.O. Box 1990, Atlanta, GA 30301.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner *Sonny Perdue, Governor*

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

October 1, 2009

Dear State Health Benefit Plan (SHBP) Member:

Welcome to the 2010 Open Enrollment. This year the Open Enrollment will be held October 9–November 10, 2009. Employees will again make their health election on the Web at www.oe2010.ga.gov.

SHBP is committed to providing a comprehensive benefit program while trying to keep prices affordable for all members. During these current financial times, we are faced with decisions that require us to balance our finances while maintaining the standard and quality of care you have come to expect from SHBP. As a result, there will be a number of changes for active members as well as retirees.

Active Member Changes:

- There are a number of changes for the plans offered to our active members.
Please carefully read these changes before making your decision

Be assured that the Georgia Department of Community Health, which administers SHBP, is committed to providing you with meaningful choices while keeping costs down. Be assured that we will continue to seek to provide you with multiple options and the tools to help you make the best decisions for you and your family members.

Sincerely,

A handwritten signature in cursive script, appearing to read "Rhonda M. Medows".

Rhonda M. Medows, M.D.
Commissioner

Equal Opportunity Employer

Contents

Phone Numbers, Contacts and Provider Information	Inside Front Cover
Changes for All SHBP Members	Page 3
Open Enrollment	Page 7
Understanding Your Plan Options	Page 12
SHBP Eligibility	Page 15
If You Are Retiring	Page 17
Health & Wellness	Page 19
Benefits Comparison	Page 20
Important Notices	Page 28

Common Acronyms

CDHP – Consumer Driven Health Plan

CMS – Centers for Medicare & Medicaid Services

COB – Coordination of Benefits

DCH – Georgia Department of Community Health

FSA – Flexible Spending Account

HDHP – High Deductible Health Plan

HMO – Health Maintenance Organization

HRA – Health Reimbursement Arrangement

HSA – Health Savings Account

IRS – Internal Revenue Service

MAPD PFFS – Medicare Advantage with Prescription Drugs Private Fee-for-Service

OAP – Open Access Plan: Open Access Plus-CIGNA and Choice Plus-UHC

OE – Open Enrollment

PCF – Personalized Change Form

PCP – Primary Care Physician

SHBP – State Health Benefit Plan

SPD – Summary Plan Description

UHC – UnitedHealthcare

Welcome to Open Enrollment for the State Health Benefit Plan for Coverage Effective January 1, 2010–December 31, 2010

The Open Enrollment dates are October 9 through November 10, 2009. This guide will provide you with a brief explanation of each Plan option, important changes in your SHBP options, steps on how to make your Open Enrollment election, information about the health and wellness features available through the health plan options and a comparison of benefits chart. This guide, the *Active Employee Decision Guide*, can also be found at www.dch.georgia.gov/shbp_plans or www.oe2010.ga.gov.

Employees will make their health election at www.oe2010.ga.gov and the Web site will be open beginning 4 a.m. on October 9 and will close at 4:30 p.m. on November 10, 2009.

Changes for All SHBP Members

- Kaiser Permanente will no longer be offered
- There will be an increase in premiums of 10 percent for all plans
- Plan Changes to all options
- Spousal Surcharge will increase from \$30 to \$40
- Tobacco Surcharge will increase from \$40 to \$60
- Open Access Plans (OAP): CIGNA Open Access Plus and United Choice Plus (in place of the PPO). *See page 6 for more information.*

Transition of Care – Kaiser Members

- Transition of care may be received if treatment is needed for certain conditions after December 31, 2009. To request transition of care, call your health plan's Customer Service number early in December but no later than December 31, 2009
- If your Kaiser provider is a community specialist and is participating in the new plan you select, benefits for any covered medical services will be covered under the new Plan effective January 1, 2010
- If you have any medical or pharmacy claims for services on or before December 31, 2009, these claims should be filed with Kaiser Permanente by June 30, 2010 at the following address:
 - Kaiser Permanente
 - Claims Administration
 - P.O. Box 190849
 - Atlanta, GA 31119-0849

No claims will be processed after this date.

Coordination of Benefits (COB) Policy Change for the OAP and HRA Options

To make our COB policy consistent across all options, we are changing the COB policy for the OAP and HRA options. This means when you have other group coverage or Medicare and SHBP coverage, the benefit under SHBP will be no greater than it would have been if there was no coverage other than that of SHBP. For example, many times when you went to the doctor, you did not have to pay anything – not even a co-pay. Under the new COB rule, you would owe the co-pay when you go to the doctor for an office visit because the SHBP benefits require a co-pay.

SHBP Plan Changes for 2010

HMO PLAN BENEFITS		
Deductible	January 1, 2009	January 1, 2010
• Employee	\$400	\$600
• ES Employee + Spouse	\$600	\$900
• EC Employee + Child(ren)	\$600	\$900
• Family	\$800	\$1200
Out-of-Pocket Maximum		
• Employee	\$1500	\$2000
• ES Employee + Spouse	\$2250	\$3000
• EC Employee + Child(ren)	\$2250	\$3000
• Family	\$3000	\$4000
Co-insurance	10%	20%
Office Visit Co-pay	\$30	\$35
ER Co-pay	\$100	\$150
Rx Drug Co-pay	\$10/30/75 <i>2 co-pays for 90 day supply</i>	\$15/40/75 <i>3 co-pays for 90 day supply</i>

OPEN ACCESS PLAN BENEFITS – <i>Replacing PPO*</i>				
Deductible	January 1, 2009		January 1, 2010	
	In-Network	Out-of-Network	In-Network	Out-of-Network
• Employee	\$500	\$1000	\$600	\$1200
• ES Employee + Spouse	\$1000	\$2000	\$1200	\$2400
• EC Employee + Child(ren)	\$1000	\$2000	\$1200	\$2400
• Family	\$1500	\$3000	\$1800	\$3600
Out-of-Pocket Maximum				
• Employee	\$1500	\$3000	\$2000	\$4000
• ES Employee + Spouse	\$2250	\$4500	\$3000	\$6000
• EC Employee + Child(ren)	\$2250	\$4500	\$3000	\$6000
• Family	\$3000	\$6000	\$4000	\$8000
Co-insurance	10%/40%		20%/40%	
Office Visit Co-pay	\$30		\$35	
ER Co-pay	\$100		\$150	
Rx Drug Co-pay	\$10/30/100		\$15/40/100	

*CIGNA's *Open Access Plus* and *UnitedHealthcare's Choice Plus Open Access* plans replace the PPO. See page 6 for further information.

HRA PLAN BENEFIT				
Deductible	January 1, 2009		January 1, 2010	
	• Employee	\$1000	\$1100	
• ES Employee + Spouse	\$1750	\$1900		
• EC Employee + Child(ren)	\$1750	\$1900		
• Family	\$2500	\$2750		
Out-of-Pocket Maximum				
• Employee	\$2000	\$2500		
• ES Employee + Spouse	\$3250	\$4100		
• EC Employee + Child(ren)	\$3250	\$4100		
• Family	\$4500	\$5700		
Co-insurance	10%/40%		15%/40%	
Rx Drug Co-pay	10%		15% generic, 25% brand*	

*See page 26 for more information

HDHP PLAN BENEFIT				
Deductible	January 1, 2009		January 1, 2010	
	In-Network	Out-of-Network	In-Network	Out-of-Network
• Employee	\$1150	\$2300	\$1200	\$2400
• ES Employee + Spouse	\$2300	\$4600	\$2400	\$4800
• EC Employee + Child(ren)	\$2300	\$4600	\$2400	\$4800
• Family	\$2300	\$4600	\$2400	\$4800
Out-of-Pocket Maximum				
• Employee	\$1700	\$3800	\$1800	\$4000
• ES Employee + Spouse	\$2900	\$7000	\$3100	\$7400
• EC Employee + Child(ren)	\$2900	\$7000	\$3100	\$7400
• Family	\$2900	\$7000	\$3100	\$7400

Open Access Plan Option

Effective January 1, 2010, as part of the on-going effort to control escalating medical costs, SHBP will offer an Open Access Plan Option (OAP) instituting a different network provider contract with UnitedHealthcare (UHC). The providers participating in UHC's OAP network are very similar to the one currently being used by the SHBP although you may see some difference. As you may know, the CIGNA option for SHBP members has been an Open Access product since January 1, 2009. The options referred to generically as PPO going forward will be referred to as Open Access Plans. When confirming a current provider or searching for a new provider you should use CIGNA's "Open Access Plus" and UHC's "Choice Plus" networks.

The OAPs function like the PPO plans that were offered last year, with benefits for In-Network and Out-of-Network coverage. You can choose any network physician or health care professional without a referral, and you will continue to receive the highest level of benefits under your plan when you use In-Network providers. In addition, like the PPO, under the OAP there's no requirement for designating a primary care physician; however, the selection of a primary care physician is highly encouraged. Both CIGNA and UHC OAPs include continued access to a comprehensive network of hospitals, facilities, other health care professionals and pharmacies in Georgia and nationwide receiving benefits for office visits, hospital care (inpatient and outpatient) as well as other benefits previously received under the PPO.

Utilizing this network allows for greater provider negotiated discounts for most services and there's minimal difference in the network makeup. We are confident that this change in network will cause very little disruption or inconvenience to SHBP members.

You will not see any significant differences in the covered services that were offered to you under the PPO options as a result of the options now being referred to as an OAP. However, there are plan design changes that are required in 2010 on all options offered to SHBP members such as deductibles, out-of-pocket limits, co-pays and coinsurance as a result of the State's fiscal situation. Please read your benefit materials carefully to understand the changes on all options.

Open Enrollment

Who Must Participate in Open Enrollment?

EVERYONE who wants to:

- Continue current health coverage and not pay surcharges
- Change coverage tiers
- Add or disenroll eligible dependents
- Change health coverage options
- Discontinue coverage
- Enroll for health coverage

What Should I Do before I Go Online for Open Enrollment?

- Evaluate your health care needs
- Read this *Decision Guide* completely for important information about Plan changes
- If you are enrolled in Kaiser Permanente you will need to make a new selection during Open Enrollment
- Check to see if your option will be offered in 2010
- Check premium rates with your employer or at www.dch.georgia.gov/shbp_plans to help you decide between options
- Call each Plan option or go to the vendor Web site to see which option your physician or provider participates in
- Check the distance you will have to drive to see your provider(s)
- Check Preferred Drug List – co-pays or co-insurance amount
- Check browser requirements – you will need Internet Explorer 5.5 or higher
- If you are actively working and are considering enrolling in Medicare or have already enrolled in Medicare, remember that SHBP must pay primary benefits and Medicare will provide secondary benefits
- If you plan to retire during the year, carefully review the Retiree as well as the Active Decision Guides. The Retiree Decision Guide is available at www.dch.georgia.gov/shbp_plans

Go online at www.oe2010.ga.gov October 9–November 10, 2009 to complete Open Enrollment. It's fast, easy, and secure! If you do not have access, please go to your personnel/payroll office for assistance.

Follow these Steps to Make Your OE Election Online

1. Go to www.oe2010.ga.gov
 - a) Register the first time you logon, by clicking on “Register”
 - b) Enter your policy number (Social Security Number) and date of birth
 - c) Create, enter and re-enter the password to confirm (please remember this password for future reference)
 - d) Select a security question and answer it
 - e) Complete by clicking “Register”
 - f) You are now logged in. If you exit the system, you will be directed to the “login” screen to enter your policy number and the password you chose above
2. After reading the “Terms, Conditions and Instructions”, scroll to the end of the text, click on the “I Agree” button
3. Your name and address will display. If needed, make any changes. Place a ‘check’ in the check box to confirm that you have validated your address
4. You will now see information from Thomson Reuters who manages the SHBP data. This information compares your 2008 medical and prescription claims cost against the 2010 plan options and premium structure. The analysis will show which SHBP option for 2010 is expected to have the lowest cost based on the 2008 claims experience
5. Select one of the tiers based on the dependents you wish to cover in 2010
6. If employee only tier is chosen, you will proceed to the tobacco surcharge question. If you choose one of the other tiers to cover a spouse and/or dependent, the dependents screen will appear. Indicate ‘Yes’ or ‘No’ for each dependent to be covered. If you wish to add a new dependent, click on “Add Dependent,” input the new dependent information, and click the “Add Dependent” button. Your new dependent should appear

7. Answer the surcharge questions
8. Select your health benefit coverage option
9. A considerations page will be displayed. Please read this page carefully as it is designed to assist you with items you may wish to consider before confirming your election. If you wish to change your election after reviewing this page, click on the “Return” button to go back to the Coverage Selection page. If you are satisfied with your election, click on the “Confirm” button
10. A Pre-Confirmation page will be displayed. Review your health benefit election, listed dependents and answers to the surcharge questions. If your election is not correct, make any corrections through the edit function. Click ‘Confirm’ to finalize your election
11. This is your confirmation page, which reflects your 2010 benefit election. Click ‘Printer Friendly’ to produce an easy to print version of your confirmation page, which will include a confirmation number. You may also save your confirmation on your computer or to a disk by saving the printer friendly confirmation as a pdf file. This confirmation page is your record of your election. Each time you login to the system and confirm your choices, you will receive a unique confirmation number which you should print or save. The benefits elected and confirmed as of 4:30 p.m. on November 10, 2009 will be your benefit election for the 2010 Plan Year. *NOTE: If a confirmation number does not show, you have not completed the process. You must click “Confirm” to complete your election. If you are unable to print or save this page, copy the confirmation number and keep it in a safe place*
12. Click on “Logout” to exit
13. Do not wait until the last minute to go online to make your election for 2010 as Web traffic may be heavy and exceptions will not be allowed if you were unable to complete your 2010 election. REMINDER: the Web site will close at 4:30 p.m. EST on November 10, 2009

If you are unable to access www.oe2010.ga.gov to make your OE election, contact your personnel/payroll office for assistance prior to the close of OE.

**having a baby?
adopting a child? getting
married or divorced?**

**Remember you only
have 31 days from the
qualifying event to add
or delete dependents by
contacting SHBP.**

SHBP Surcharges

You should read and understand SHBP's surcharge policy prior to making your health election for 2010.

Spousal

A \$40 per month spousal surcharge will be added to your monthly premium if you elect to cover your spouse and your spouse is eligible for coverage through his/her employment, but chooses not to elect that coverage. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived. You will automatically be charged the surcharge if you fail to go online and answer all questions concerning the surcharge. The surcharge will apply to your premium for the 2010 Plan Year.

Please note that SHBP may audit any member covering a spouse who does not pay the spousal surcharge.

Tobacco

A \$60 per month tobacco surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous 12 months or if you fail to go online and answer these questions. The surcharge will apply to your premium for the 2010 Plan Year.

The tobacco surcharge may be removed by completing the tobacco cessation requirements. Details are available at www.dch.georgia.gov/shbp_plans. *NOTE: No refunds in surcharges can be given.*

Intentional misrepresentation in response to surcharge questions will have significant consequences. You will automatically lose State Health Benefit Plan coverage for 12 months beginning on the date that your false response is discovered.

What Happens if I Don't Go Online During Open Enrollment?

- If you are enrolled in Kaiser Permanente and fail to go online to make a new health election, you will automatically be enrolled in the CIGNA HRA Option effective January 1, 2010, and you will be assessed the tobacco surcharge and the spousal surcharge (if you cover your spouse)
- If you are enrolled in a CIGNA or UHC option, your coverage will roll over to the same option and you will be assessed the tobacco surcharge and the spousal surcharge (if you cover your spouse)

State Personnel Administration (SPA) Flexible Benefits Program Participants [formerly Georgia Merit System (i.e. dental, life, etc.)]

- You will need to go to www.oe2010.ga.gov to make your health benefit election. You should print your confirmation page and make sure it contains a confirmation number. This number confirms your health benefit election for 2010
- If you are eligible for SPA flexible benefits (i.e. dental, life, etc.), you will need to go to a separate Web site, www.team.georgia.gov/flex. You should confirm your flexible benefits elections and print your confirmation statement that includes the confirmation number for your elections

Your 2010 elections must be made on two separate Web sites and you must confirm on both. You should print your confirmations (health and flex) and make sure they both contain confirmation numbers.

Board of Education or Agencies Not Participating in the SPA Flexible Benefits Program (formerly the Georgia Merit System)

You will need to make your health election on www.oe2010.ga.gov, print your confirmation and make sure it contains a confirmation number. This number confirms your health benefit election for 2010. Contact your personnel/payroll office to obtain information regarding your flexible benefits.

CIGNA and UnitedHealthcare Each Offer:

- Health Reimbursement Arrangement (HRA)
- High Deductible Health Plan (HDHP)
- Open Access Plan (OAP) replaces the PPO: Open Access Plus (CIGNA), Choice Plus (UHC)
- Health Maintenance Organization (HMO)

Understanding Your Plan Options

Health Reimbursement Arrangement (HRA)

The HRA is a Consumer Driven Health Plan option (CDHP) whose plan design offers you a different approach for managing your health care needs. It is similar to that of the OAP with an in-network and out-of-network benefit, except SHBP funds dollar credits to your HRA each year to provide first dollar coverage for eligible health care and pharmacy expenses. Unused dollars in your HRA account roll over the next Plan year if you are still participating in this option, but will be forfeited if you change options during Open Enrollment or due to a qualifying event.

Plan Features

- The plan offers unlimited wellness benefits based on age and gender national guidelines when seeing in-network providers only
- HRA dollar credits are part of this option only and can only be used with the HRA option
- The amount in your HRA is used to reduce the deductible and maximum out-of-pocket
- There is not a separate deductible and out-of-pocket maximum for out-of-network expenses
- After satisfying your deductible, you will pay your coinsurance amount until you reach your out-of-pocket maximum
- Certain drug costs are waived if SHBP is primary and you participate in one of the Disease State Management Programs (DSM) for Diabetes, Asthma and/or Coronary Artery Disease

High Deductible Health Plan (HDHP)

The HDHP design is very similar to that of the OAP with an in-network and out-of-network benefit.

In return for a low monthly premium, you must satisfy a high deductible that applies to all health care expenses except preventive care. **If you have family coverage, you must meet the ENTIRE family deductible before benefits are payable for any family member. You pay co-insurance after you have satisfied the deductible rather than set dollar co-payments for medical expenses and prescription drugs.** Also, you may qualify to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses now or in the future. HSAs typically earn interest and may even offer investment options. *See the benefits comparison chart that starts on page 20 to compare benefits under the HDHP to other Plan options.*

Plan Features:

- This option offers 100 percent unlimited wellness benefits based on national age and gender guidelines
- You must satisfy a separate in-network and out-of-network deductible and out-of-pocket maximum
- You pay co-insurance after meeting the entire family deductible for all medical expenses and prescriptions
- This plan is not creditable so if you don't sign up for Medicare when you first become eligible; you may be charged a late enrollment penalty

Open Access Plans (OAP)

OAP options allow you to receive benefits from in-network and out-of-network providers, and provides access on a statewide and national basis across the United States. To receive the highest level of benefit coverage and to avoid filing claims and balance billing, you should use an in-network provider. If you use an out-of-network provider, the reimbursement will be lower and you will be subject to balance billing from your provider.

Plan Features

- You do not have to select a primary care physician (PCP) or obtain a referral to see a specialist; however, you are encouraged to select a PCP to help coordinate your care
- You must satisfy a separate in-network and out-of-network deductible and separate out-of-pocket maximum
- Out-of-network benefits are subject to balance billing (the amount above the negotiated rate approved by the vendor)
- Co-payments do not apply toward deductibles or out-of-pocket maximum unless otherwise noted

Health Maintenance Organization (HMO)

An HMO allows you to obtain benefits from participating providers only and does not require you to select a Primary Care Physician (PCP). HMOs provide 100 percent benefit coverage for preventive health care needs after paying applicable co-payments. Certain services are subject to a deductible and co-insurance. *See pages 20–27 for more information.*

Plan Features

- Both CIGNA and UnitedHealthcare provide a national network and services are paid at the same benefit levels when using network providers outside of Georgia
- You do not have to obtain a referral to see a specialist; however, you are encouraged to select a PCP to help coordinate your care
- Coverage is available only when using in-network providers (except in cases of emergencies)
- Co-payments do not count toward your deductible or out-of-pocket maximum

**adopting a child?
getting married
or divorced?**

**Remember you only
have 31 days from the
qualifying event to
add dependents by
contacting SHBP.**

Health Savings Account (HSA) – For Information Only

An HSA is like a personal savings account with investment options for health care, except it's all tax-free. You may open an HSA with a bank or an independent HSA administrator/custodian.

You may open an HSA if you enroll in the SHBP HDHP and do not have other coverage through: 1) Your spouse's employer's plan 2) Medicare 3) Medicaid 4) General Purpose Health Care Spending Account (GPHCSA) or any other non-qualified medical plan.

- You can contribute up to \$3,050 single, \$6,150 family as long as you are enrolled in the HDHP. These limits are set by federal law. Unused money in your account carries forward to the next Plan Year and earns interest
- HSA dollars can be used for eligible health care expenses even if you are no longer enrolled in the HDHP or any SHBP coverage
- HSA dollars can be used to pay for health care expenses (medical, dental, vision, over-the-counter medications) that the IRS considers tax-deductible that are **NOT** covered by any health plan (see IRS Publication 502 at www.irs.gov)
- You can contribute an additional \$1,000 if you are 55 or older (see IRS Publication 502 at www.irs.gov)

	HRA	HSA
Overview	A tax-exempt account that reimburses retirees and dependents for qualified medical expenses. Can be funded by employer only.	A tax-exempt custodial account that exclusively pays for qualified medical expenses of the employee and his or her dependents. Can be funded by retiree, employer, or other party.
Who is eligible?	Available to SHBP members enrolled in an HRA. <i>See benefits chart for amounts funded by SHBP.</i>	Available to SHBP members who elect HDHP and may enroll in an HSA of your choice.
Can I have other coverage and take advantage of this benefit?	Yes.	No other general medical insurance coverage permitted. You cannot be enrolled in Medicare Parts A or Part B.
Who owns the money in these accounts?	SHBP. Money reverts back to SHBP upon loss of SHBP HRA coverage.	The member.
Can these dollars be rolled over each year?	Yes.	Yes.
Is there a monthly service charge?	No.	Check with your HSA administrator.
If I terminate my SHBP coverage or change options...	Unused amounts can be distributed until depleted to pay for claims incurred before termination.	Fund disbursement is not tied to individual's employment. Unused amounts can be distributed tax-free for qualified medical expenses. Subject to income and excise tax for non-qualified expenses.

SHBP Eligibility

The SHBP covers dependents who meet SHBP guidelines and requires eligibility documentation before SHBP can send dependents' notification of coverage to the health plans.

Eligible Dependents Are:

- **Your legally married spouse**, as defined by Georgia Law
- **Your never-married dependent children who are:**
 1. **Natural or legally adopted children under age 19**, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody
 2. **Stepchildren under age 19 who live with you** at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents
 3. **Other children under age 19** if they live with you permanently and legally depend on you for financial support – as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction
 4. **Your natural children, legally adopted children or stepchildren** who are physically or mentally disabled prior to reaching age 26 and who depend on you for primary support and meet clinical guidelines
 5. **Your natural children, legally adopted children, stepchildren or other children ages 19 through 25 from categories 1, 2, or 3 above** who are registered full-time students at accredited secondary schools, colleges, universities or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for full-time student status is defined by the school in which the child is enrolled

SHBP requires documentation annually from the college or university your student attends verifying he/she is a full-time student.

Making Changes When You Have a Qualifying Event

If you experience a qualifying event, you may be able to make changes for yourself and your dependents, **provided you make the request to SHBP within 31 days of the qualifying event**. Also, your requested change must correspond to the qualifying event. For a complete description of qualifying events, see your Summary Plan Description. You can contact the Eligibility Unit for assistance at 800-610-1863 or in the Atlanta area at 404-656-6322.

Qualifying Events Include, but Are Not Limited to:

- Birth or adoption of a child, or placement for adoption
- Change in residence by you, your spouse or dependents that results in ineligibility for coverage in your selected option because of location
- Death of a spouse or child, if the only dependent enrolled
- Your spouse's or dependent's loss of eligibility for other group health coverage
- Marriage or divorce
- Medicare eligibility

health tip:

Eating a low-fat, low-sugar diet with plenty of fruits and vegetables can boost your physical and mental health.

Please submit your request, within 31 days of the event to your personnel/benefit coordinator. Requests should not be held while waiting for additional information, such as Social Security Number, marriage or birth certificate. SHBP will accept dependent verification at anytime during the Plan Year and coverage will be retroactive to the qualifying event date or first of the Plan Year, whichever is later as long as the request is received within 31 days of the qualifying event. SHBP will NOT change the tier because of a failure to verify dependent eligibility. The tier will be in effect for the plan year unless there is a qualifying event which allows for a change.

Documentation Confirming Eligibility for Your Spouse or Dependents

SHBP requires documentation concerning eligibility of dependents covered under the plan.

- **Spouse:** A copy of your certified marriage certificate or a copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out
- **Natural or student child:** A copy of the certified birth certificate listing the parents by name or a letter of confirmation of birth for newborns. Birth cards without the parents' names are not acceptable
- **For students age 19 through age 25,** SHBP requires the child's birth certificate and documentation from the school's registrar's office verifying full-time student status and a completed and signed student status form
- **Stepchild:**
 1. A copy of the certified birth certificate showing your spouse is the natural parent;
 2. A copy of the certified marriage certificate showing the natural parent is your spouse; and
 3. A notarized statement that the dependent lives in your home at least 180 days per year

NOTE: No health claims will be paid until the documentation is received and approved by SHBP. The member's Social Security Number **MUST** be written on each document so we can match your dependents to your record. Do not send originals as they will not be returned.

What if I Am Working and Am Eligible for Medicare?

Federal Law requires SHBP to pay primary benefits for active employees and their dependents. Active members or their covered dependents may choose to delay Medicare enrollment. Termination of active employment is a qualifying event for enrolling in Medicare without penalty. *Except HDHP, see page 31.*

If You Are Retiring . . . What You Need to Know

State Health Benefit Plan (SHBP) Medicare Policy

If you want to have health insurance under SHBP when you retire, you must enroll for coverage for you and any eligible dependents during the Open Enrollment period prior to your retirement.

Once retired, you will have an annual Retiree Option Change Period (ROCP) that allows you to change your Plan option only. You may add dependents only if you experience a qualifying event and request the change within 31 days and provide the documentation required by SHBP.

The following information and “Important Notices about Your Prescription Drug Coverage and Medicare” are provided to assist you with Retirement Planning. *See Page 28.*

If You Are Retiring and You or Any of Your Covered Dependents Are Not Eligible for Medicare

SHBP will pay primary benefits for the retiree and any covered dependents. You will have the same SHBP options as active employees.

Your options and premiums change when you become eligible for Medicare. *See below for more information.*

If You Are Retiring and You or Any of Your Covered Dependents Are Eligible for Medicare

The premiums you pay and your options change when you or one of your dependents become eligible for Medicare because of age (65 years) or disability.

IMPORTANT NOTE:

THERE IS CRITICAL INFORMATION ABOUT SHBP OPTIONS AND PREMIUMS FOR RETIREES IN THE RETIREE DECISION GUIDE. IT IS YOUR RESPONSIBILITY FOR READING THIS INFORMATION.

Your SHBP premiums will increase the first of the month in which you or a dependent reaches age 65 or becomes eligible for Medicare due to disability. When you enroll for Medicare Part B, you will pay a monthly premium for this coverage to Social Security. You should mail a copy of your Medicare Parts A and B card and confirmation of Part D coverage to SHBP at P.O. Box 1990, Atlanta, GA 30301-1990 and include the social security number of the SHBP retiree. This information should be forwarded to SHBP 60 days prior to the first of the month in which you or a covered dependent become eligible for Medicare. Upon receipt, SHBP will adjust your premiums to reflect your Medicare coverage. SHBP is not able to refund premiums when notification is not received timely.

If you have Medicare due to End Stage Renal Disease (ESRD), you will need to contact the Social Security Administration to determine when Medicare becomes primary.

Medicare information is available at:

- www.cms.hhs.gov
- www.medicare.gov
- www.ssa.gov
- 1-800-669-8387 (Georgia Cares)
- 1-800-633-4227 (Medicare)

If you have questions about your SHBP options and premiums when you plan to retire, call the SHBP Call Center at (404) 656-6322 or 1 (800) 610-1863.

Health & Wellness

Did You Know?

- Cardiovascular Disease is the leading cause of death in Georgia
- Diabetes in Georgia is 8% higher than the nation as a whole
- Asthma has been diagnosed in approximately 210,000 children in Georgia between the ages of 0–17 years old
- Certain drug costs are waived for HRA and OAP members who participate in the Disease State Management (DSM) Programs for Cardiovascular Disease, Diabetes or Asthma

What Can You Do About Your Health?

Take a Personal Health Assessment at least once a year to assist you in learning about potential health risks related to your lifestyle and family history. Each vendor has a health assessment questionnaire available on their Web site that you can complete. After completing the health assessment you will get a customized report that identifies health risks and provides recommendations on ways to help you reduce health risks and suggestions on how to make better lifestyle choices. *Members who complete the health assessment may be contacted by the vendor's registered nurses or health coaches regarding steps they can take to control or eliminate these risks. Participant data is completely confidential and individual results are not shared with your employer or SHBP.*

Utilize the Preventive Health and Wellness Services: One of the best ways to stay healthy is to take advantage of preventive health care. Check with the vendor regarding the plan option you choose to confirm which preventive services are covered. In addition, each vendor offers health coaching and wellness programs such as weight loss, nutrition, and stress management. Contact the vendors to learn more about the programs they offer or visit their Web site to view available services.

Engage in the Health Management Services: Each vendor offers assistance with health care services including disease management, case management and behavioral health. Please contact the vendor of choice for additional details on programs offered such as the DSM Program that waives prescription drug co-payments/costs on certain medications for members who have Cardiovascular Disease, Diabetes and/or Asthma and remain compliant with the DSM Program requirements.

Call the Nurse Advice Line: Each vendor has a 24-hour, seven days a week (including holidays) nurse advice line that is available to assist you in making informed decisions about your health. Check with your health plan option for the telephone number.

Good health is priceless. When you live a healthy lifestyle, you can feel better, live easier and save money on health care expenses!

Benefits Comparison: OAP – HRA – HDHP – HMO

Schedule of Benefits for You and Your Dependents for January 1, 2010 – December 31, 2010

Covered Services	OPEN ACCESS OPTION		HRA OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Covered Services	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Maximum Lifetime Benefit (combined for all SHBP Options)	\$2 million		\$2 million	
Pre-Existing Conditions (first year in Plan only, subject to HIPAA)	\$1,000		Not applicable	
Lifetime Benefit Limit for Treatment of: (combined for Open Access Option and HDHP) • Temporomandibular joint dysfunction (TMJ)	\$1,100		\$1,100	
Deductibles/Co-Payments: EE = Employee ES = Employee + Spouse EC = Employee + Child(ren) EF = Employee + Spouse + Child(ren) • Hospital deductible per admission	\$600 \$1,200 \$1,200 \$1,800	\$1,200 \$2,400 \$2,400 \$3,600	\$1,100* \$1,900* \$1,900* \$2,750*	<i>*HRA credits will reduce this amount.</i> Not applicable
Out-of-Pocket Maximum: EE = Employee ES = Employee + Spouse EC = Employee + Child(ren) EF = Employee + Spouse + Child(ren)	\$2,000 \$3,000 \$3,000 \$4,000	\$4,000 \$6,000 \$6,000 \$8,000	\$2,500* \$4,100* \$4,100* \$5,700*	<i>HRA credits will reduce this amount.</i>
HRA Credits: EE = Employee ES = Employee + Spouse EC = Employee + Child(ren) EF = Employee + Spouse + Child(ren)	None		\$500 \$1,000 \$1,000 \$1,500	
Physicians' Services				
Primary Care Physician or Specialist Office or Clinic Visits: Treatment of illness or injury	\$35 per office visit co-payment; subject to deductible for associated lab and x-ray	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive health care • Annual gynecological exams (these services are not subject to the deductible)	\$35 co-payment per office visit; No co-payment for associated tests and immunizations; Maximum of \$1000 per person per Plan Year	Not covered. Charges do not apply to deductible or annual out-of-pocket limits	100% coverage; not subject to deductible	Not covered. Charges do not apply to deductible or annual out-of-pocket limits

Dollar amounts, visit limitations, deductibles and out-of-pocket limits are based on a January 1–December 31, 2010 Plan Year. NOTE: Coverage is defined as allowed eligible expenses. Exclusions and limitations vary among Plan options. Contact your specific Plan option for more information.

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS
In-Network	Out-of-Network	In-Network Only
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>
\$2 million		\$2 million
Not applicable		Not applicable
\$1,100		No separate lifetime benefit limit
\$1,200 \$2,400 \$2,400 \$2,400	\$2,400 \$4,800 \$4,800 \$4,800	\$600 \$900 \$900 \$1,200
Not applicable		Not applicable
\$1,800 \$3,100 \$3,100 \$3,100	\$4,000 \$7,400 \$7,400 \$7,400	\$2,000 \$3,000 \$3,000 \$4,000
None		None
90% coverage; subject to deductible	60% coverage; subject to deductible	\$35 per office visit co-payment
100% coverage; not subject to deductible	Not covered; Charges do not apply to deductible or annual out-of-pocket limits	100% after a per visit co-payment of \$35 for primary care and specialty care; No co-payment for immunizations and mammograms

	OPEN ACCESS OPTION		HRA OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Physicians' Services	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Maternity Care (prenatal, delivery and postpartum)	80% coverage; not subject to deductible after initial \$35 co-payment	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services Furnished in a Hospital • Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services for Emergency Care Non-emergency use of the emergency room not covered	80% coverage; subject to in-network deductible		85% coverage; subject to in-network deductible	
Outpatient Surgery— • When billed as office visit	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
• When billed as outpatient surgery at a facility	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Allergy Shots and Serum	100% for shots and serum; \$35 per visit co-payment not subject to deductible (no co-payment if office visit not billed)	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services				
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage after deductible; and subject to a \$250 per admission deductible	60% coverage after deductible; and subject to a \$250 per admission deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
• Well-newborn care	100% coverage; not subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery— Hospital/facility	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Emergency Care—Hospital • Treatment of an emergency medical condition or injury • Non-emergency use of the emergency room not covered	80% coverage after \$150 per visit co-payment; co-payment waived if admitted; subject to in-network deductible		85% coverage; subject to deductible	

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS
In-Network	Out-of-Network	In-Network Only
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after initial \$35 co-payment
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
90% coverage; subject to in-network deductible		100% (\$150 co-pay applies to facility expenses)
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$35 co-payment if billed as office visit
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% for shots and serum after a \$35 per visit co-payment; No co-pay if office visit not billed
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage not subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
90% coverage; subject to in-network deductible		100% after a \$150 per visit co-payment; if admitted co-payment waived; subject to deductible

	OPEN ACCESS OPTION		HRA OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Testing, Lab, etc.	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Non Routine Laboratory; X-Rays; Diagnostic Tests; Injections —including medications covered under medical benefits—for the treatment of an illness or injury	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Behavioral Health				
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization NOTE: Contact vendor regarding prior authorization.	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits and Intensive Outpatient NOTE: All services require prior authorization.	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Dental				
Dental and Oral Care NOTE: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury.	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
NOTE: Notification required for all UHC options.				
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to \$1,100 per person lifetime maximum benefit. This limit does not apply to the HMO.	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Vision				
Routine Eye Exam NOTE: Limited to one eye exam every 24 months.	80% coverage; not subject to deductible	Eye exam not covered	100% coverage; not subject to deductible	Eye exam not covered
Other Coverage				
Hearing Services Routine hearing exam	Not covered		85% coverage for routine exam and fitting; subject to deductible. \$1,500 hearing aid allowance every 5 years; not subject to the deductible	
Ambulance Services for Emergency Care NOTE: “Land or air ambulance” to nearest facility to treat the condition.	80% coverage; subject to in-network deductible		85% coverage; subject to in-network deductible	
Urgent Care Services NOTE: All subject to deductible except HMO.	80% coverage after a \$45 per visit co-payment	60% coverage	85% coverage; subject to deductible	60% coverage; subject to deductible

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS
In-Network	Out-of-Network	In-Network Only
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; not subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$35 per visit co-payment. \$10 co-payment for group therapy
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$35 per visit co-payment; if inpatient/outpatient facility, 80% subject to deductible
NOTE: Notification required for all UHC options.		
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$35 co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/outpatient facility, 80% subject to deductible
100% coverage; not subject to deductible	Eye exam not covered	100% after \$35 co-payment; not subject to deductible. \$200 annual benefit for glasses and contacts
90% coverage for route exam and fitting; subject to deductible. \$1,500 hearing aid allowance every 5 years; not subject to the deductible		Not covered
90% coverage; subject to in-network deductible		100% coverage; not subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$35 co-payment

	OPEN ACCESS OPTION		HRA OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Home Health Care Services NOTE: Prior approval required.	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services NOTE: Prior approval required.	80% coverage after deductible; up to 120 days per Plan Year; subject to a \$250 per admission deductible	Not covered	85% coverage; up to 120 days per Plan Year; subject to deductible	Not covered
Hospice Care NOTE: Prior approval required.	100% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME) —Rental or purchase NOTE: Prior approval required for certain DME.	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services <ul style="list-style-type: none"> • Physical Therapy • Speech Therapy • Occupational Therapy • Other short term rehabilitative services 	80% coverage; subject to deductible; \$20 per visit co-payment up to 40 visits per Plan Year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per Plan Year (not to exceed a total of 40 visits, including any in-network visits)	85% coverage; subject to deductible; up to 40 visits per Plan Year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per Plan Year (not to exceed a total of 40 visits combined, including any in-network visits)
Chiropractic Care NOTE: Coverage for up to a maximum of 20 visits per Plan Year.	80% coverage; after a \$35 per visit co-payment; not subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services NOTE: Prior approval required.	80% coverage at contracted transplant facility; subject to deductible and \$250 per admission deductible	Not covered	85% coverage; subject to deductible	60% coverage; subject to deductible
Pharmacy – You Pay				
Tier 1 Co-payment NOTE: No Tiers in HRA Option	\$15	\$15*	15% generic; 25% brand; subject to deductible	40% generic; 40% brand; subject to deductible*
Tier 2 Co-payment	\$40	\$40*	Not applicable	Not applicable
Tier 3 Co-payment	\$100	\$100*	Not applicable	Not applicable
Tier 4 Co-payment	Not applicable	Not applicable	Not applicable	Not applicable

*Member must pay full charges at point of sale and submit a paper claim. Members will be reimbursed at the pharmacy network rate less the required co-payment for covered drugs. Member is responsible for charges that exceed the pharmacy network rate.

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS
In-Network	Out-of-Network	In-Network Only
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; up to 120 visits per Plan Year
90% coverage up to 120 days per Plan Year; subject to deductible	Not covered	80% coverage; up to 120 days per Plan Year; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage when medically necessary
90% coverage up to 40 visits per therapy per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage up to 40 visits per therapy per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any in-network visits)	100% coverage after \$25 per visit co-payment; up to 40 visits per therapy per Plan Year
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after \$35 co-payment per visit
90% coverage at contracted transplant facility; subject to deductible	Not covered	80% coverage; subject to deductible
20% coverage; subject to deductible; \$10 min.; \$100 max.	Not covered	\$15
20% coverage; subject to deductible; \$10 min.; \$100 max.	Not covered	\$40
20% coverage; subject to deductible; \$10 min.; \$100 max.	Not covered	\$75
Not applicable	Not covered	Not covered

About the Following Notices

The notices on the following pages are required by the Center for Medicaid & Medicare Services (CMS) to explain what happens if you buy an individual Medicare Prescription Drug (Part D) Plan. The chart below explains what happens if you buy an individual Medicare Part D Plan.

YOUR SHBP OPTION	WHAT HAPPENS IF YOU BUY AN INDIVIDUAL MEDICARE PART D PLAN
SHBP Medicare Advantage Standard or SHBP Medicare Advantage Premium Plan	You will permanently lose SHBP coverage if you purchase a Part D Plan once enrolled in a SHBP Medicare Advantage Plan. You will not pay a Medicare “late enrollment” penalty.
Open Access Plan/HRA HDHP	Your Medicare Part D Plan will be primary for your prescription drugs unless you are in the deductible or doughnut hole and then SHBP will provide benefits. If you reach the Out-of-Pocket Limit, SHBP will coordinate benefits with your Medicare Part D Plan. You will not pay a Medicare “late enrollment” penalty.
HDHP (High Deductible)	You will have to pay a Medicare “late enrollment” penalty if you miss the initial enrollment period because the HDHP option is not considered “creditable coverage.”

These notices state that prescription drug coverage under all SHBP coverage options except for the HDHP (High Deductible) option is considered Medicare Part D “creditable coverage.” This means generally that the prescription drug coverage under SHBP MA Standard, SHBP MA Premium, OAP, HMO, and HRA are all “as good or better than” the prescription drug coverage offered through Medicare Part D plans that are sold to individuals.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Two Peachtree Street • Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2009

About Your Prescription Drug Coverage with CIGNA and UnitedHealthcare OAP, HMO and Medicare

For Plan Year: January 1–December 31, 2010

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to learn about your current coverage and Medicare's prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The SHBP has determined that the prescription drug coverage offered by the CIGNA and UnitedHealthcare OAP, HMO and HRA offered under SHBP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage. **Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Do Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your SHBP coverage will be affected. You can keep your SHBP coverage if you elect Part D and SHBP will coordinate with Part D coverage the month following receipt of enrollment notice. Your premiums will also be reduced by each Part of Medicare you have. You should send a copy of your Medicare cards to SHBP at P. O. Box 1990, Atlanta, GA 30301.

If you do decide to join a Medicare drug plan and drop your coverage with the State Health Benefit Plan, be aware that you and your dependents can not get this coverage back if you are a retiree.

WARNING! Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could **AUTOMATICALLY** and **PERMANENTLY END** your SHBP Coverage.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without credible prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about this Notice or Your SHBP Current Prescription Drug Coverage...

Contact the SHBP Eligibility Unit at (404) 656-6322 or (800) 610-1863. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the State Health Benefit Plan changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2010

Name of Sender: State Health Benefit Plan

Office: Call Center

Address: P. O. Box 1990, Atlanta, GA 30301

Phone Number: (404) 656-6322 or (800) 610-1863



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Two Peachtree Street • Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2009

Important Notice from the SHBP about Your Prescription Drug Coverage and Medicare

About Your Prescription Drug Coverage with the CIGNA and UnitedHealthcare High Deductible Health Plan (HDHP) and Medicare

For Plan Year: January 1–December 31, 2010

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The SHBP has determined that the prescription drug coverage offered by the HDHP Option, is on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. **This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the HDHP offered by SHBP. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. You can keep your current coverage in a CIGNA or UnitedHealthcare HDHP offered by the SHBP. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. *Read this notice carefully as it explains your options.*

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

Since the HDHP coverage under SHBP is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without credible prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without credible coverage, your premium may consistently be at least 19% higher than

WARNING! Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you decide to drop your current coverage under SHBP, since it is an employer sponsored group plan, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan, however you also may pay a higher premium (a penalty) because you did not have Credible Coverage under SHBP.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your HDHP coverage under SHBP will be affected. If you enroll in Medicare Part D when you become eligible for Medicare Part D, you can keep your HDHP coverage and the HDHP will coordinate benefits with the Part D coverage. If you do decide to join a Medicare drug plan and drop your HDHP coverage under SHBP, be aware that you and your dependents will not be able to get your SHBP coverage back if you are a retiree.

You should also know that if you drop or lose your HDHP coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

For More Information about this Notice or Your Current Prescription Drug Coverage...

Contact the SHBP Call Center at (404) 656-6322 or (800) 610-1863 for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SHBP changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 1, 2010

Name of Sender: State Health Benefit Plan

Office: Call Center

Address: P. O. Box 1990, Atlanta, GA 30301

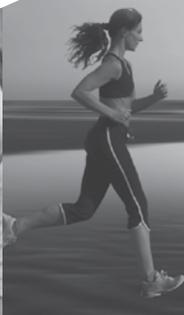
Phone Number: (404) 656-6322 or (800) 610-1863

Notify the Plan of any fraudulent activity regarding Plan members, providers, payment of benefits, etc. Call 1-877-878-3360 or 404-463-7590.

Penalties for Misrepresentation

If an SHBP participant misrepresents eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against the participants, including but not limited to terminating coverage (for the participant and his or her dependent(s) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law.

In order to avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH